1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

19407

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

19413

1. DECEASED-NAME (Type or Print) First: JAMES Middle: IGNATIUS Last: Butler

2a. DATE KNOWN OF DEATH ☒ / ESTIMATED ☐: Month 12 Day 12 Year 1971

2b. HOUR: 1145 M

3. SEX: M

4. RACE: W

5. DATE OF BIRTH: 4-4-04

6. AGE (In years last birthday): 67 YRS. IF UNDER 1 YEAR: MONTHS / DAYS. IF UNDER 24 HRS: HOURS / MIN

2c. DATE PRONOUNCED DEAD: Month 12 Day 12 Year 1971

2d. HOUR: 1145 M

7a. BIRTHPLACE (State or foreign country): NEW YORK

7b. CITIZEN OF WHAT COUNTRY? USA

8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

9. COUNTY OF DEATH: WORCESTER Md.

10. CITY OR TOWN OF DEATH: Ocean City

11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Quality Motel

12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): LAWYER

12b. KIND OF BUSINESS OR INDUSTRY: US Govt.

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md

13b. COUNTY: Baltimore

13c. CITY OR TOWN: Towson

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET AND NUMBER: 803 Starbit Court

14. FATHER'S NAME First: THOMAS Middle Last: Butler

15. MOTHER'S MAIDEN NAME First: MARY Middle Last: Moore

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)

16b. SOCIAL SECURITY NO.: 216-44-6659

17. INFORMANT (W, F) ADDRESS: MRS. MARY C. BUTLER Towson, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): CORONARY THROMBOSIS, ACUTE — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: MOMENTS

DUE TO, OR AS A CONSEQUENCE OF (b): ASCVD with Hypertension — 10 YEARS

DUE TO, OR AS A CONSEQUENCE OF (c):

4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY? YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19

21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)

21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: F. J. Townsend Jr. M.D.

EXAMINER'S NAME (Type): F. J. Townsend, JR

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

ADDRESS (Street, City, Town, or County): Ocean City, Md.

22b. DATE SIGNED: 12/12/71

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE: 12-15-71

23c. NAME OF CEMETERY OR CREMATORY: Dulaney Valley Mem

23d. LOCATION (City or Town) (County) (State): Timonium Balt. Md.

24. FUNERAL DIRECTOR: Wm. Cook-Brooks Towson, Inc.

ADDRESS: 1050 York Rd Towson, Maryland

25a. REC'D BY REGISTRAR DATE: DEC 17 1971

25b. REGISTRAR'S SIGNATURE: Vernon A. Randall

VR A15ME (5) 8M-1/70

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MD. 21201

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 1, Give Items 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form VM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18,22a Film 444

MARYLAND STATE DEPARTMENT OF HEALTH

19408 1/28/72

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

19414

FOR STATE HEALTH DEPT.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health priar to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5) 8M-1/70

1. DECEASED-NAME (Type or Print)	First: Kendall	Middle: Tommy	Last: Cropper	2a. DATE KNOWN OF DEATH ☒ / ESTIMATED ☐	Month: Dec	Doy: 1	Year: 19 71
2b. HOUR	3:00 A.M.						
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday) YRS.	IF UNDER 1 YEAR: MONTHS	DAYS	IF UNDER 24 HRS: HOURS	MIN
M	N	Oct 23, 71		1	8		
2c. DATE PRONOUNCED DEAD	Month: Dec	Doy: 1	Year: 19 71	2d. HOUR	3:00 A.M.		
7a. BIRTHPLACE (State or foreign country)	Salisbury, Md	7b. CITIZEN OF WHAT COUNTRY?	USA	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH	Worcester	Md.
10. CITY OR TOWN OF DEATH	Pocomoke City	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	100 E 6th St	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	—
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	Md	13b. COUNTY	Wor	13c. CITY OR TOWN	Pocomoke	13d. INSIDE CITY LIMITS? YES ☐ NO ☐	13e. STREET AND NUMBER: 100 E 6th St
14. FATHER'S NAME First	Middle	Last		15. MOTHER'S MAIDEN NAME First	Middle	Last	
Woodrow	Thomas	Cropper		Gwendolyn	LORRAINE	Johnson	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
No		—		Mrs Gwendolyn Cropper		100 E 6th St Pocomoke, Md	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Pending Sudden Death in Infancy — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

795X

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) _____

DUE TO, OR AS A CONSEQUENCE OF

(c) _____

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that I taak charge of the remains described above, held an Autopsy ☒, Inspectian ☐, Inquiry ☐, and in my opinian death resulted from: Naturol couses ☒, Accident ☐, Suicide ☐, Hamicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE _____ M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☐

EXAMINER'S NAME (Type) F S Townsend, Jr. ADDRESS (Street, city, Town, or county) Crisfield, Md

22b. DATE SIGNED Dec 4, 1971

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	12-4-71	Tabernacle	Hortons Accomack Va.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Samuel Savage — New Church, Va.	DEC 9 1971	Vernon B. Randall

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

19409

CERTIFICATE OF DEATH

19415

1. DECEASED-NAME (Type or print) First	Middle	Lost	2a. DATE OF DEATH Month Day Year	2b. HOUR
Selina	E.	Hickman	Dec. 24 1971	9P M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
Female	Negro	Jan 29, 1893	78 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐	9. COUNTY OF DEATH
North Carolina	USA		Worcester Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Snow Hill	Rt. 1	Housewife	Own Home

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES ☐ NO ☑	13e. STREET AND NUMBER
Maryland	Worcester	Snow Hill		

14. FATHER'S NAME First	Middle	Lost	15. MOTHER'S MAIDEN NAME First	Middle	Lost
Cisero		Harris	Elizabeth		Powell

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
No	Unknown	Mrs. Sallie W. Johnston, Snow Hill Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	ACUTE CORONARY OCCLUSION	1/2 HR
DUE TO, OR AS A CONSEQUENCE OF (b)	ARTERIO SCLEROTIC CARDIOVASCULAR DISEASE	10 YRS
DUE TO, OR AS A CONSEQUENCE OF (c)		

4109
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)
OSTEOPOROSIS & ASCITES

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	Stote

22a. **I certify** that (I) (this hospital) attended the deceased from Nov 1, 1971, to Dec 24, 1971, that (I) (~~we~~) last saw the deceased alive on Dec 24 1971, and that in (my) (~~our~~) opinian death accurred on the date and haur and from the causes stated ~~above~~, (I) (~~we~~) (~~did~~) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS. ☒	MED. DIRECTOR ☐	STAFF PHYS. ☐	22c. DATE SIGNED
J. Robert La Mar					12-25-71

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
ROBERT C. LA MAR	004 Bay St Snow Hill, Md. 21863

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY ~~OR CREMATORY~~	23d. LOCATION (City or Town) (County) (Stote)
Burial	Dec. 30, 1971	Zion Hill Baptist	Littleton, N.C.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Truman F. Kemp	Snow Hill, Md.	DEC 28 1971	Vernon G. Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper (pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

19410

19416

FOR STATE HEALTH DEPT.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in part in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or Print) First	Middle	Lost
Beatrice	Mae	Hill

2a. DATE KNOWN OF ESTIMATED ☑ Month Doy Year: Dec 14 1971 — 2b. HOUR: M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN
Female	White	April 30 1906	65 YRS.		

2c. DATE PRONOUNCED DEAD Month Doy Year 19 — 2d. HOUR: M

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
Delaware	USA		Worcester Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Snow Hill	519 S. Church St.	Housewife	Own Home

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Maryland	Worcester	Snow Hill	YES ☑ NO ☐	519 S. Church St.

14. FATHER'S NAME First	Middle	Lost	15. MOTHER'S MAIDEN NAME First	Middle	Lost
Robert	Marvel		Mattie		Lloyd

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		221 09 2375	Harry M. Hill	Snow Hill Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) ACUTE CORONARY OCCLUSION — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: MINUTES

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4109

DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIO SCLEROTIC CORONARY ARTERY DISEASE — 10 YRS

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

DIABETES

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Doy, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Robert C. La Mar M.D.

EXAMINER'S NAME (Type): ROBERT C. LA MAR, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

ADDRESS (Street, city, town or county): 104 Bay St Snow Hill, Maryland

22b. DATE SIGNED: 12-18-71

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY ~~OR CREMATORY~~	23d. LOCATION (City or Town)	(County)	(State)
Burial	12-17-71	Odd Fellow	Seaford		Del.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Clayton M. Watson	SEAFORD DEL	DEC 27 1971	Vernon G. Randall

VR A15ME (5) 8M-1/70

Items 18,22a Film 44 1/28/72 mh

19411

19417

MARYLAND STATE DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE HEALTH DEPT.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PME-Page 2 mo. prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health. Page 4 should be retained for your files.

VR A15ME (5) 8M-1/70

1. DECEASED-NAME (Type or Print)	First: WILLIAM	Middle: PAUL	Last: KANTZ	2a. DATE KNOWN OF ESTIMATED DEATH: Month Dec Day 14 Year 1971	2b. HOUR 3P M	
3. SEX: M	4. RACE: W	5. DATE OF BIRTH: 10/5/07	6. AGE (In years last birthday): 64 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.	2c. DATE PRONOUNCED DEAD: Month Dec Day 14 Year 1971 — 2d. HOUR 3P M
7a. BIRTHPLACE (State or foreign country): MISSOURI	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH: WORCESTER Md.			
10. CITY OR TOWN OF DEATH: RD-1 Ocean City	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Salisbury Road	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): FARMER	12b. KIND OF BUSINESS OR INDUSTRY: FARM			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md	13b. COUNTY: WOR	13c. CITY OR TOWN: Ocean City	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET AND NUMBER: RD1 Salisbury Rd.		
14. FATHER'S NAME: First PAUL — Middle — Last KANTZ	15. MOTHER'S MAIDEN NAME: First Amelia Middle — Last STAPP					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes give war or dates of service): WWII	16b. SOCIAL SECURITY NO.: 075 10 1531	17. INFORMANT: Mrs Clara KANTZ (WIFE)	ADDRESS: 18 Eden Drive COMMACK NY			

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) PENDING Pulmonary Edema — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Dilation of R atrial & Ventricle, Acute

DUE TO, OR AS A CONSEQUENCE OF

(c) ASCVD, Coronary, Aorta

4124

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☒ NO ☐
21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State

22a. **I certify** that I took charge of the remains described above, held on Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE F. J. Townsend Jr. M.D.

EXAMINER'S NAME (Type) F. J. TOWNSEND, JR.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

ADDRESS (Street, City, Town, or County) Berlin Md

22b. DATE SIGNED 12/15/71

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 12/18/71	23c. NAME OF CEMETERY OR CREMATORY SUNSET MEM. PK.	23d. LOCATION (City or Town) BERLIN,	(County) WOR. (State) MD.
24. FUNERAL DIRECTOR ULLRICH FUNERAL HOME	ADDRESS BERLIN, MD.	25a. RECD BY REGISTRAR DATE DEC 20 1971	25b. REGISTRAR'S SIGNATURE Vernon G. Randall	

1

19412

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

19418

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
ANNIE	CUSTIS	MILLER	December 23, 1971	M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
Female	White	July 15, 1896	75 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒	9. COUNTY OF DEATH
Virginia	U.S.A.		WORCESTER Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Pocomoke City	902 Walnut Street	none	--

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER
Maryland	Worcester	Pocomoke		902 Walnut Street

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
James	M.	Custis	McCreany	--	Justis

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
no	--	217-03-9051	Mrs Jane Cutler, same 13a,b,c,e.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Ventricular fibrillation — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Minutes

DUE TO, OR AS A CONSEQUENCE OF

(b) Degenerative arteriosclerotic

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF Heart Disease — Years

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

1. Diabetes Mellitus 2. Chronic Nephritis

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING CAUSE OF DEATH ☐ OR CONTRIBUTING ☐ (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State

22a. **I certify** that (I) (~~this hospital~~) attended the deceased from Oct. 7, 1964, to Dec. 23, 1971, that (I) (~~we~~) last saw the deceased alive on Dec. 23, 1971, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the couses stoted above, (I) (~~we~~) (did) (~~did not~~) view the body after death.

22b. SIGNATURE Charles W. Trader M.D. DEGREE — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22c. DATE SIGNED Dec.24,1971

22d. PHYSICIAN'S NAME (Type) Charles W. Trader, M.D. — 22e. ADDRESS 302 Market St., Pocomoke City, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	12-26-1971	Salem Methodist	Pocomoke City-Wor.-Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Robert H. Watson	Pocomoke City, Md.	DEC 28 1971	Vernon B. Randall

Robert H. Watson

VR A15 (4)
25m-1/70

Items 18-22a Film 44 2/8/72 mh

MARYLAND STATE DEPARTMENT OF HEALTH

19413

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

19419

FOR STATE HEALTH DEPT.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 3 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5) 8M-1/70

1. DECEASED-NAME (Type or Print): First LILA Middle ELLA Last MURRAY

2a. DATE OF DEATH: KNOWN ☒ ESTIMATED ☐ Month 12 Day 13 Year 1971

2b. HOUR 3:30 P.M.

3. SEX: F

4. RACE: W

5. DATE OF BIRTH: 12/10/1905

6. AGE (In years last birthday): 66 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS MIN.

2c. DATE PRONOUNCED DEAD: Month 12 Day 13 Year 1971

2d. HOUR 3:30 P.M.

7a. BIRTHPLACE (State or foreign country): Md

7b. CITIZEN OF WHAT COUNTRY? U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. COUNTY OF DEATH: WORCESTER Md.

10. CITY OR TOWN OF DEATH: Bishopville

11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): RURAL

12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Housewife

12b. KIND OF BUSINESS OR INDUSTRY: —

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md

13b. COUNTY: WOR

13c. CITY OR TOWN: Bishopville

13d. INSIDE CITY LIMITS? YES ☐ NO ☒

13e. STREET AND NUMBER: RURAL RI Box 71

14. FATHER'S NAME First George Middle W. Last Hudson

15. MOTHER'S MAIDEN NAME First MARY Middle E Last QUILLEN

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)

16b. SOCIAL SECURITY NO.

17. INFORMANT: Ollie Hudson (Brother) ADDRESS: R 4 Box 145 Berlin Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

963X IMMEDIATE CAUSE (a) PENDING Asphyxia

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) obstruction of nose and mouth during assault

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY? YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 3:00 P.M. 12-13 19 71

21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.): Assaulted by gang

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.): Home

21f. LOCATION Street or R.F.D. No. City or Town: Bishopville County: Wor. State: Md.

22a. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☒, Undetermined manner ☐

ACTUAL SIGNATURE: [signature] M.D.

EXAMINER'S NAME (Type): F J Townsend Jr. Ocean City Md.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☐

ADDRESS (Street, city, town, or county)

22b. DATE SIGNED: 12/13/71

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE: 12/17/71

23c. NAME OF CEMETERY OR CREMATORY: Oddfellows Cem.

23d. LOCATION (City or Town) (County) (State): Bishopville, Wor. Md.

24. FUNERAL DIRECTOR: A. Douglas Melson ADDRESS: Frankford, Del.

25a. REC'D BY REGISTRAR DATE: JAN 4 1972

25b. REGISTRAR'S SIGNATURE: Vernon R. Randall

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19414

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

19420

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print): First: Viola; Middle: ---; Last: Stein

2a. DATE OF DEATH: Month Day Year: December 27, 1971

2b. HOUR: M

3. SEX: Female

4. RACE: White

5. DATE OF BIRTH: July 8, 1917

6. AGE (In years last birthday): 54 YRS. IF UNDER 1 YEAR: MONTHS DAYS; IF UNDER 24 HRS.: HOURS MIN.

7a. BIRTHPLACE (State or foreign country): Minnesota

7b. CITIZEN OF WHAT COUNTRY?: U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. COUNTY OF DEATH: WORCESTER Md.

10. CITY OR TOWN OF DEATH: Pocomoke City

11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): 106 Laurel Street

12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Housewife

12b. KIND OF BUSINESS OR INDUSTRY: --

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland

13b. COUNTY: Worcester

13c. CITY OR TOWN: Pocomoke

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET AND NUMBER: 106 Laurel Street

14. FATHER'S NAME First: Ray; Middle: --; Last: Dickinson

15. MOTHER'S MAIDEN NAME First: Mathilda; Middle: --; Last: Heinz

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no

(If yes give war or dates of service): --

16b. SOCIAL SECURITY NO.: unk

17. INFORMANT Address: Clarence J. Hagel, same 13a, b, c, e.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Coronary Occlusion — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Minutes

DUE TO, OR AS A CONSEQUENCE OF

(b): Atherosclerotic Heart Disease — Years

DUE TO, OR AS A CONSEQUENCE OF

(c):

4109 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

1. Sarcoidosis 2. Cor Pulmonale

19a. DATE OF OPERATION:

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20a. AUTOPSY? YES ☐ NO ☐

20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS OR CONTRIBUTING ☐ UNDERLYING CAUSE OF DEATH ☐ (If either, notify medical examiner)

21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19

21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐

21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)

21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that (I) (this hospital) attended the deceased from 10-6-677, 19____, to 12-27-71, 19____, that (I) (we) last saw the deceased alive on ____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Charles W. Trader MD

DEGREE: ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22c. DATE SIGNED: 12-28-71

22d. PHYSICIAN'S NAME (Type): Charles W. Trader, MD.,

22e. ADDRESS: 302 Market St., Pocomoke City, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE: 12-31-1971

23c. NAME OF CEMETERY OR CREMATORY: Calvery Cemetery

23d. LOCATION (City or Town) (County) (State): St. Cloud, Minnesota

24. FUNERAL DIRECTOR: Robert H. Watson

ADDRESS: Pocomoke City, Md.

25a. REC'D BY REGISTRAR DATE: JAN 3 1972

25b. REGISTRAR'S SIGNATURE: Vernon O. Randall

VR A15 (4) 25m-1/70

1

19415

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

19421

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First: Nancy	Middle:	Last: Taylor	2a. DATE OF DEATH Month: Dec. Day: 19 Year: 1971 — 2b. HOUR: 8:20 A.M.
3. SEX: Female	4. RACE: Negro	5. DATE OF BIRTH: Apr. 21, 1906	6. AGE (In years last birthday): 65 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN.
7a. BIRTHPLACE (State or foreign country): Md.	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH: Worcester Md.
10. CITY OR TOWN OF DEATH: Stockton	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): home Stockton	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Laborer	12b. KIND OF BUSINESS OR INDUSTRY: Factory
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md.	13b. COUNTY: Worcester	13c. CITY OR TOWN: Stockton	13d. INSIDE CITY LIMITS? YES ☒ NO ☐ — 13e. STREET AND NUMBER: P.O. Box 83
14. FATHER'S NAME First: Edward	Middle:	Last: Selby	15. MOTHER'S MAIDEN NAME First: Cora	Middle:	Last: Smith
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service): No	16b. SOCIAL SECURITY NO.	17. INFORMANT: Mabel Savage	Address: New Church, Va.		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Multiple Myeloma — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 4 mos.
DUE TO, OR AS A CONSEQUENCE OF
(b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 203 X
DUE TO, OR AS A CONSEQUENCE OF
(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☑	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS OR CONTRIBUTING ☐ UNDERLYING CAUSE OF DEATH ☐ (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State	

22a. **I certify** that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Donald J. Annuien	DEGREE: MD	ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐	22c. DATE SIGNED: 12-23-71
22d. PHYSICIAN'S NAME (Type): DONALD J. ANNUIEN	22e. ADDRESS: CHINCOTEAGUE, VA		

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 12-26-71	23c. NAME OF CEMETERY OR CREMATORY: Home Beneficial Cem.	23d. LOCATION (City or Town): Stockton	(County): Wor.	(State): Md.
24. FUNERAL DIRECTOR: [signature]	ADDRESS: New Church, Va.	25a. REC'D BY REGISTRAR DATE: JAN 3 1972	25b. REGISTRAR'S SIGNATURE: Vernon R. Randall		

VR A15 (4)
25m-1/70

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

19416

CERTIFICATE OF DEATH

19422

1. DECEASED-NAME (Type or print): First: Cora; Middle: Mae; Last: Timmons
2a. DATE OF DEATH: Month: Dec.; Day: 28; Year: 1971
2b. HOUR: 7A M
3. SEX: Female
4. RACE: White
5. DATE OF BIRTH: Aug 24 1886
6. AGE (In years last birthday): 85 YRS. IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.
7a. BIRTHPLACE (State or foreign country): Delaware
7b. CITIZEN OF WHAT COUNTRY?: USA
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
9. COUNTY OF DEATH: Worcester Md.
10. CITY OR TOWN OF DEATH: Snow Hill
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): 120 Ironshire St.
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Housewife
12b. KIND OF BUSINESS OR INDUSTRY: Own Home
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland
13b. COUNTY: Worcester
13c. CITY OR TOWN: Snow Hill
13d. INSIDE CITY LIMITS? YES ☑ NO ☐
13e. STREET AND NUMBER: 120 Ironshire St.
14. FATHER'S NAME: First: William; Middle: T.; Last: Layton
15. MOTHER'S MAIDEN NAME: First: Sallie; Middle: ; Last: Wilson
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)
16b. SOCIAL SECURITY NO.: None
17. INFORMANT: Address: Mrs. Ernestine T. Collins, Snow Hill, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Chronic myocarditis
DUE TO, OR AS A CONSEQUENCE OF (b): Arterio-sclerosis
DUE TO, OR AS A CONSEQUENCE OF (c): Hypertension
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 402X
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 5 yrs

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES ☐ NO ☑
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)
21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While at work ☐ Not while at work ☐
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that (I) (this hospital) attended the deceased from 1965, 19___, to 12-28-71, 1971, that (I) (we) last saw the deceased alive on 12-28-71 19___, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Frank Lewis
DEGREE: ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22c. DATE SIGNED: 12-30-71
22d. PHYSICIAN'S NAME (Type): Frank Lewis
22e. ADDRESS: Willards Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 12-30-71
23c. NAME OF CEMETERY OR CREMATORY: McHenie Presby
23d. LOCATION (City or Town) (County) (State): Snow Hill, Md.
24. FUNERAL DIRECTOR: ADDRESS: Vernon G. Ennis, Snow Hill, Md.
25a. REC'D BY REGISTRAR DATE: JAN 3 1972
25b. REGISTRAR'S SIGNATURE: Vernon G. Randol

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
45M - 1/69

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

19417 — 19423

1. DECEASED-NAME (Type or print): First WADDELL Middle J. Lost WHITTINGTON
2a. DATE OF DEATH: Month DEC Day 29 Year 1971
2b. HOUR: M
3. SEX: M
4. RACE: W
5. DATE OF BIRTH: JULY 7, 1900
6. AGE (In years last birthday): 71 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS
IF UNDER 24 HRS.: HOURS / MIN
7a. BIRTHPLACE (State or foreign country): MARYLAND
7b. CITIZEN OF WHAT COUNTRY?: U.S.A.
8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
9. COUNTY OF DEATH: WORCESTER Md.
10. CITY OR TOWN OF DEATH: GIRDLETREE
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): —
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): RETIRED
12b. KIND OF BUSINESS OR INDUSTRY:
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND
13b. COUNTY: WOR
13c. CITY OR TOWN: BERLIN
13d. INSIDE CITY LIMITS? YES [X] NO [ ]
13e. STREET AND NUMBER: —
14. FATHER'S NAME First — Middle — Lost —
15. MOTHER'S MAIDEN NAME First OLIVIA Middle WHITTINGTON Lost
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service)
16b. SOCIAL SECURITY NO.: 220-12-7161
17. INFORMANT Address: ROLAND WHITTINGTON OCEAN CITY MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Myocardial Infarction
DUE TO, OR AS A CONSEQUENCE OF (b): Coronary heart disease
DUE TO, OR AS A CONSEQUENCE OF (c): A.S.C.V.D.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4109
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 10 years / 10 years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES [ ] NO [ ]
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) UNDERLYING [ ]
21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19
21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.)
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
21f. LOCATION Street or R.F.D. No. City or Town County Stote

22a. I certify that (I) (~~this hospital~~) attended the deceased from Sept, 19 66, to Dec, 19 71, that (I) (~~we~~) last saw the deceased alive on 12/29/1971, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) (~~did~~) (did not) view the body after death.

22b. SIGNATURE: Frank E. Gantz Jr. MD DEGREE — ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]
22c. DATE SIGNED: 1/3/72
22d. PHYSICIAN'S NAME (Type): Frank E. Gantz Jr. MD
22e. ADDRESS: 5 Bay St. Berlin, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE: 12/31/71
23c. NAME OF CEMETERY OR ~~CREMATORY~~: EVERGREEN
23d. LOCATION (City or Town) (County) (State): BERLIN WOR MD
24. FUNERAL DIRECTOR: Anna A. Bunting ADDRESS: Berlin Md.
25a. REC'D BY REGISTRAR DATE: JAN 6 1972
25b. REGISTRAR'S SIGNATURE: Vernon B. Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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